Form 33 - Medical History Update

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Darken the oval completely next to the answer you choose.
- Erase cleanly any marks you wish to change.
- Do not make any stray marks on this form.

CORRECT MARK	INCORRECT MARKS

This form asks about any health problems and health care since:

____________ ⌊ ⌋ , 20 ⌊ ⌋
month **day** **year**

Do not report hospital admissions, medical problems or tests that happened before this date. However, if you are not sure of the date and don't think that you have reported the problem to us before, please do answer the questions about that problem.

Public reporting burden for this collection of information is estimated to average 5 + 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address.

OFFICE USE ONLY

1. **Date Received:**

   ⌊ ⌋-⌊ ⌋-⌊ ⌋ **(MM/DD/YY)**

2. **Reviewed By:**

   ⌊ ⌋-⌊ ⌋

3. **Contact Type:**
   - ☐1 Phone
   - ☐2 Mail
   - ☐8 Other

4. **Visit Type:**
   - ☐3 Annual
   - ☐4 Non-Routine

5. **Language:**
   - ■1 E
   - ☐2 S

☐ **FCA** ☐ **OU1** ☐ **OU2**

[Serial code #s]

1. What is today's date? (Write the date in the space provided and mark the corresponding bubbles below.)

   ___ ___ - ___ ___ - ___ ___
   Mo Day Yr

   Please mark only <u>one</u> bubble per line: Month
   Day
   Year

2. Who is completing this form?

   ☐1 Self - Women's Health Initiative (WHI) Extension Study participant
   ☐4 Other (on behalf of the WHI participant, specify): ________________________

3. <u>Since the date on the front of this form</u>, have you had any of the following exams, tests, or procedures done by a doctor or other health care provider?

No	Yes	
☐0	☐1	Breast exam
☐0	☐1	Mammogram
☐0	☐1	Test of breast tissue or fluid for disease (breast biopsy or aspiration)
☐0	☐1	Other <u>breast examination</u> tests such as MRI or ultrasound
☐0	☐1	Test for the presence of blood in your stool or bowel movement (hemoccult, guaiac)
☐0	☐1	Tube inserted into your bowel to check for bowel problems (sigmoidoscopy or colonoscopy).
☐0	☐1	Hysterectomy (surgery to remove the uterus or womb)
☐0	☐1	Endometrial biopsy
☐0	☐1	Bone density scan (DEXA)

Go to the next page.

4. Since the date on the front of this form, has a doctor or other health care provider told you for the first time that you have any of the following specific conditions?

No	Yes	
☐$_0$	☐$_1$	Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
☐$_0$	☐$_1$	Osteoarthritis or arthritis associated with aging
☐$_0$	☐$_1$	Macular degeneration with aging
☐$_0$	☐$_1$	Parkinson's disease
☐$_0$	☐$_1$	Intestine or colon polyps or adenomas
☐$_0$	☐$_1$	Moderate or severe memory problems (dementia or Alzheimer's)
☐$_0$	☐$_1$	Systemic lupus erythematosus (lupus)

5. Since the date on the front of this form, has a doctor or other health care provider prescribed any of the following treatments for **diabetes** for the first time?

No	Yes	
☐$_0$	☐$_1$	Insulin
☐$_0$	☐$_1$	Pills or medications other than insulin
☐$_0$	☐$_1$	Diet and/or physical activity

6. Since the date on the front of this form, has a doctor or other health care provider prescribed pills for **high blood pressure** or **hypertension** for the first time?

☐$_0$ No ☐$_1$ Yes

Go to the next page.

7. Since the date on the front of this form, how many times did you fall and land on the floor or ground?

☐ 0 None ☐ 2 2 times
☐ 1 1 time ☐ 3 3 or more times

8. Since the date on the front of this form, has a doctor or other health care provider newly diagnosed or treated any of the following, **OR** have you been hospitalized for two or more nights for any reason?

No	Yes	
☐ 0	☐ 1	Cancer, malignant growth or tumor
☐ 0	☐ 1	Broken, fractured or crushed bone
☐ 0	☐ 1	Stroke or transient ischemic attack (TIA)
☐ 0	☐ 1	Heart disease, including heart attack, heart failure, atrial fibrillation (afib), or other heart conditions
☐ 0	☐ 1	Blood clots in your lungs or legs
☐ 0	☐ 1	Blocked or narrowed arteries to the legs causing poor circulation (not varicose veins)
☐ 0	☐ 1	Hospitalized for two or more nights for any reason

If you answered "yes" to one or more of the items in question 8, please go to the next page.

If you answered NO to all of the items in question 8, you are done with this form. Thank you.

Questions on New Cancers, Malignant Growths or Tumors

9. Since the date on the front of this form, has a doctor or other health care provider told you that you have a new cancer, malignant growth or tumor? (Do not include benign tumors.)

☐ 0 No ⟶ **If no, go to question 10 on page 8.**

☐ 1 Yes

9.1 What type of cancer? **(Mark all that apply.)**	9.2 Date you were told you had this cancer (mo-day-yr)
☐ 1 Breast	___ ___- ___ ___ - ___ ___
☐ 2 Ovary	___ ___- ___ ___ - ___ ___
☐ 3 Endometrium (lining of the uterus or womb)	___ ___- ___ ___ - ___ ___
☐ 4 Cervix	___ ___- ___ ___ - ___ ___
☐ 5 Other female genital organs (not ovary, endometrium, or cervix)	___ ___- ___ ___ - ___ ___
☐ 6 Colon or rectum	___ ___- ___ ___ - ___ ___
☐ 7 Bladder or urinary tract	___ ___- ___ ___ - ___ ___
☐ 8 Brain	___ ___- ___ ___ - ___ ___
☐ 9 Esophagus	___ ___- ___ ___ - ___ ___
☐ 10 Gallbladder or bile ducts	___ ___- ___ ___ - ___ ___
☐ 11 Kidney	___ ___- ___ ___ - ___ ___
☐ 12 Leukemia; specify ____________________	___ ___- ___ ___ - ___ ___
☐ 13 Liver	___ ___- ___ ___ - ___ ___
☐ 14 Lung	___ ___- ___ ___ - ___ ___
☐ 15 Lymphoma: Hodgkin's disease	___ ___- ___ ___ - ___ ___
☐ 16 Lymphoma: Non Hodgkin's Specify _________________________	___ ___- ___ ___ - ___ ___
☐ 17 Melanoma	___ ___- ___ ___ - ___ ___
☐ 18 Multiple myeloma	___ ___- ___ ___ - ___ ___
☐ 19 Pancreas	___ ___- ___ ___ - ___ ___
☐ 20 Skin cancer **(not melanoma)**	___ ___- ___ ___ - ___ ___
☐ 21 Stomach	___ ___- ___ ___ - ___ ___
☐ 22 Thyroid	___ ___- ___ ___ - ___ ___
☐ 23 Other cancer or malignant tumor not listed above, specify:_____________________	___ ___- ___ ___ - ___ ___
☐ 24 Unknown or don't know	___ ___- ___ ___ - ___ ___

Questions on New Cancers, Malignant Growths or Tumors, continued

Please provide contact information for the doctor or other health care providers that diagnosed or treated the first cancer you reported on the previous question. If you have been recently diagnosed with more than one cancer, record the contact information for any other doctors or hospitals and the dates of admission and discharge in the Comments section at the end of this form.

9.3 How was the cancer first diagnosed? **(Mark all that apply.)**

- ☐1 Biopsy, date: Mo __ __ - Day __ __ - Yr __ __
- ☐2 CT or CAT scan
- ☐3 Blood draw or lab results
- ☐4 Bone marrow biopsy
- ☐5 PET or other imaging scan
- ☐6 Other, specify: ____________________
- ☐8 Unknown or don't know

9.4 Who was the doctor or other health care provider who diagnosed your cancer?

Provider name: ______________________________

Street address: ______________________________

____

City State Zip Code

Phone number: ( ) ______________________________

Office use only | | | |

9.5 In what hospital, radiology center, clinic, or other medical facility was your cancer first diagnosed?

Place name: ______________________________

Street address: ______________________________

____

City State Zip Code

Phone number: ( ) ______________________________

Office use only | | | |

9.6 Date you entered the hospital (if unsure, estimate the date): Mo __ __ - Day __ __ - Yr __ __

9.7 Date you left the hospital (if unsure, estimate the date): Mo __ __ - Day __ __ - Yr __ __

Questions on New Cancers, Malignant Growths or Tumors, continued

9.8 Have you had any cancer-related surgeries after the cancer was first diagnosed? (Do not include surgery if it was done during the hospital stay reported on the previous page.)

☐0 No

9.9 If no, are any planned? ☐0 No ☐1 Yes
Go to question 10 on the next page.

☐1 Yes

9.10 Number of cancer-related surgeries you have had: ⌴⌴

9.11 Type(s) of cancer-related surgery, specify: ______________________________

9.12 Date of first cancer-related surgery after the cancer was diagnosed:

Mo - Day - Yr
__ __ - __ __ - __ __

9.13 Where did you have your cancer-related surgery?

Place name: ______________________________

Street address: ______________________________

____
City State Zip Code

Phone number: ( )______________________________

Office use only | | | |

Questions on New Fractures

10. <u>Since the date on the front of this form</u>, has a doctor or other health care provider told you that you have a <u>new</u> broken, fractured, or crushed bone?

☐ 0 No → **If no, go to question 11 on page 10.**

☐ 1 Yes

10.1 Which bone(s) did you break, fracture, or crush? **(Mark all that apply.)**

☐ 1 Hip
☐ 2 Upper leg (not hip)

→ **Go to the next page.**

☐ 3 Pelvis
☐ 4 Knee (patella)
☐ 5 Lower leg or ankle
☐ 6 Foot (not toe)
☐ 7 Tailbone (coccyx)
☐ 8 Spine or back (vertebra)
☐ 9 Upper arm or shoulder
☐ 10 Elbow
☐ 11 Lower arm or wrist
☐ 12 Hand (not finger)
☐ 13 Finger or toe
☐ 14 Jaw, nose, face, and/or skull
☐ 15 Ribs and/or chest or breast bone
☐ 16 Other, specify: ____________________

→ **Go to question 11 on page 10.**

Questions on New Fractures

10.2 Was this broken, fractured, or crushed hip or upper leg bone first diagnosed or treated during a hospital stay?

☐[0] No ⟶ **If no, go to question 10.6 below.**

☐[1] Yes

10.3 In what hospital or medical facility were you diagnosed or treated for the broken, fractured, crushed hip or upper leg bone?

Place name: ______________________________

Street address: ______________________________

____

City State Zip Code

Phone number: ( ) ______________________________

Office use only |__|__|__|__|

10.4 Date you entered the hospital (if unsure, estimate the date): ____ - ____ - ____ (Mo - Day - Yr)

10.5 Date you left the hospital (if unsure, estimate the date): ____ - ____ - ____ (Mo - Day - Yr)

10.6 Was an outpatient X-ray or imaging scan (MRI) taken to diagnose the broken, fractured, or crushed hip or upper leg bone (not already reported above)?

☐[0] No ⟶ **If no, go to the next page.**

☐[1] Yes

10.7 In what hospital or medical facility was your outpatient X-ray or imaging scan (MRI) taken:

Place name: ______________________________

Street address: ______________________________

____

City State Zip Code

Phone number: ( ) ______________________________

Office use only |__|__|__|__|

10.8 Date of X-ray or other imaging scan (if unsure, estimate the date): ____ - ____ - ____ (Mo - Day - Yr)

Information on New Hospitalized Stroke, Heart, and Circulation Problems

11. Since the date on the front of this form, have you been admitted to a hospital for **one or more nights** for any of the following health problems or procedures? (**Do not include outpatient visits.)**

☐0 No ⟶ **If no, go to question 12 on page 12.**

☐1 Yes

No	Yes	
☐0	☐1	Stroke
☐0	☐1	Transient ischemic attack (TIA)
☐0	☐1	MI, heart attack (coronary, myocardial infarction)
☐0	☐1	Heart bypass operation (coronary bypass surgery or CABG)
☐0	☐1	Procedure or surgery to unblock narrowed blood vessels to your heart (opening the arteries of the heart with a stent, balloon, laser, or other device. Also called PTCA, angioplasty, coronary intervention, or PCI)
☐0	☐1	Procedure or surgery to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)
☐0	☐1	Heart failure (congestive heart failure [CHF] or HF)
☐0	☐1	Angina (chest pain from a heart problem)
☐0	☐1	Atrial fibrillation, or atrial flutter, irregular heart beat, requiring medications or a procedure (electrical shock, cardioversion, ablation, or surgery) to control.
☐0	☐1	Heart valve problem or surgery to repair or replace a heart valve
☐0	☐1	Abdominal aortic aneurysm (AAA) requiring surgery or stent
☐0	☐1	Blood clots in the veins of your legs (deep vein thrombosis or DVT)
☐0	☐1	Blood clots in your lungs (pulmonary embolism or PE)
☐0	☐1	Poor blood circulation or blocked or narrowed arteries to your legs or feet (claudication, peripheral arterial disease, gangrene, or Buerger's disease; not varicose veins or blood clots in veins)
☐0	☐1	Other heart or circulation problems: ________________________________

Information on New Hospitalized Stroke, Heart, and Circulation Problems, continued

Please give the details of the first two hospital stay(s) for your stroke, heart, or circulation problems or procedures that you marked on the previous page.

11.2 **First hospital admission**

Hospital name: ______________________________

Street address: ______________________________

____
City State Zip Code

Phone number: ( )______________________________

Office use only | | | |

11.3 Date you entered the hospital (if unsure, estimate the date): Mo - Day - Yr

11.4 Date you left the hospital (if unsure, estimate the date): Mo - Day - Yr

11.5 **Second hospital admission**

Hospital name:______________________________

Street address: ______________________________

____
City State Zip Code

Phone number: ( )______________________________

Office use only | | | |

11.6 Date you entered the hospital (if unsure, estimate the date): Mo - Day - Yr

11.7 Date you left the hospital (if unsure, estimate the date): Mo - Day - Yr

11.8 Did you have any other hospital stays for health problems or procedures for your stroke, heart or circulation problems?

☐ 0 No → **Go to the next page.**

☐ 1 Yes ↓

11.9 How many other hospital stays? ☐ 1 1 stay ☐ 2 2 stays ☐ 3 3 or more stays

Please record additional provider information (hospital name, address and phone number and dates of admission and discharge) in the Comments section at the end of this form.

Information on New Outpatient Stroke, Heart, and Circulation Problems, continued

12. Since the date on the front of this form, have you been diagnosed or treated as an outpatient (not admitted to a hospital overnight) for any of the following conditions or procedures not already reported in Question 11?

No	Yes	
☐ 0	☐ 1	Stroke
☐ 0	☐ 1	Procedure to unblock narrowed blood vessels to your heart (opening the arteries of the heart with a stent, balloon, laser, or other device. Also called PTCA, angioplasty, coronary intervention, or PCI)
☐ 0	☐ 1	Electrical shock, cardioversion or ablation procedure to correct atrial fibrillation (afib) or atrial flutter
☐ 0	☐ 1	Stent, surgery or angioplasty to open blocked or narrowed arteries to your legs or feet
☐ 0	☐ 1	Stent for aortic abdominal aneurysm (AAA)
☐ 0	☐ 1	Blood clots in the veins of your legs (deep vein thrombosis or DVT)
☐ 0	☐ 1	Shots (such as Lovenox, Arixtra, or heparin) for blood clots in the veins of your legs (usually followed by blood thinning pills such as Coumadin or warfarin)

If you checked "yes" to one or more items, please provide contact information for the outpatient doctor or other health care provider (for the first box checked above). If you marked more than one box, enter additional provider information in the Comments section at the end of the form.

12.1 Date you were diagnosed or treated (if unsure, estimate the date): Mo __ __ - Day __ __ - Yr __ __

12.2 Where did you receive your first diagnosis or treatment?

Place name: ______________________

Street address: ______________________

____
City State Zip Code

Phone number: ( ) ______________________

Office use only __ __ __ __

Information on Hospital Stays (not already reported on this form)

13. Since the date on the front of this form, have you been admitted to a hospital for **two** or more nights? (Do not include an overnight stay that you have already reported on this form.)

☐0 No ⟶ **If no, go to the instructions at the end of the next page.**

☐1 Yes

13.1 How many hospital stays **of two or more nights**? ☐1 1 ☐2 2 ☐3 3 or more

Please give the details of your first two hospital stay(s) since the date on the front of this form. **If you have any other two night hospital stays, please record the contact information and dates of admission and discharge in the Comments section at the end of the form.**

13.2 First hospital admission of **two or more nights**.

Hospital name:____

Street address:____

____

City State Zip Code

Phone number: ( )____________________________

Office use only | | | |

13.3 Date you entered the hospital (if unsure, estimate the date): Mo - Day - Yr

13.4 Date you left the hospital (if unsure, estimate the date): Mo - Day - Yr

13.5 Reason for this hospital admission: **(Mark all that apply.)**

- ☐1 Appendectomy or removal of appendix
- ☐2 Back surgery such as laminectomy, spinal fusion
- ☐3 Bowel or intestinal obstruction (not cancer)
- ☐4 Gallbladder attack or gallbladder surgery
- ☐5 Hernia repair
- ☐6 Joint repair or replacement
- ☐7 Non-cancer gynecologic surgeries: such as bladder suspension; vaginal, uterine, rectal prolapse; stress incontinence
- ☐88 Other reasons: (Specify)______________________________

13.6 ☐9 Office use only

Information on Hospital Stays (not already reported on this form)

13.7 Second hospital admission of **two or more nights**.

Hospital name: ____________________

Street address: ____________________

____

City State Zip Code

Phone number: ( ) ____________________

Office use only | | | |

13.8 Date you entered the hospital (if unsure, estimate the date): Mo - Day - Yr

13.9 Date you left the hospital (if unsure, estimate the date): Mo - Day - Yr

13.10 Reason for this hospital admission: **(Mark all that apply.)**

- ☐1 Appendectomy
- ☐2 Back surgery such as laminectomy, spinal fusion
- ☐3 Bowel or intestinal obstruction (not cancer)
- ☐4 Gallbladder attack or gallbladder surgery
- ☐5 Hernia repair
- ☐6 Joint repair or replacement
- ☐7 Non-cancer gynecologic surgeries: such as bladder suspension; vaginal, uterine, rectal prolapse; stress incontinence
- ☐88 Other reasons: (Specify) ____________________

13.11 ☐9 Office use only

Please complete and sign the Authorization to Release Medical Records on the back of this form.

Thank you. Please take a moment to review any questions you may have missed. Feel free to write any comments on the next page.

You may receive a follow-up call to clarify your answers on this form.

Please report comments and additional provider information below.

WOMEN'S HEALTH INITIATIVE

Women's Health Initiative
Clinical Coordinating Center
Fred Hutchinson Cancer
Research Center
1100 Fairview Ave. N.
PO Box 19024, M3-A410
Seattle, WA 98109-1024
1-800-xxx-xxx

WHI Regional Centers
To Be Named

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Protected Health Information)

Name of facility/provider:____

The Women's Health Initiative (WHI) Extension Study is a national study sponsored by the National Institutes of Health (NIH) whose ongoing purpose is to learn about the health of post-menopausal women. By signing this form, I give permission to the named facility to give information about my health care and health conditions to: the investigators at the WHI Clinical Coordinating Center (CCC) and the Regional Center affiliates.

The information released will only be used for research purposes by the WHI and will be held in strict confidence. Examples of medical information to be requested:

Discharge summary	Emergency room records	Lab tests and results
History and physical	Operative reports	Consultations
Radiology/imaging	Procedure reports	Outpatient/short stay records
Pathology reports/specimens		MD notes/progress notes

By signing, I acknowledge that I have read and understood the following:

- Signing this authorization is voluntary.
- I have the right to revoke (cancel) this authorization at any time by notifying the WHI in writing. If I do this, it will be in effect immediately as soon as it is received and no further information about my health care and health conditions will be requested. If I revoke this authorization, it will have no effect whatsoever on my enrollment or participation in WHI.
- The above medical records may be shared with researchers at the WHI CCC at the Fred Hutchinson Cancer Research Center, WHI Regional Centers or their affiliates, the NIH (study sponsor), and regulatory agencies and review boards who watch over the safety, effectiveness and conduct of the research. The HIPAA Privacy Rule may no longer protect the information but the WHI, as a nationally funded research study, has established continued protection for the disclosed information.
- WHI **cannot** further use or disclose the information in my medical records without my consent.
- This authorization shall remain valid for the duration of the WHI Extension Study (2010-2015).
- A photocopy or facsimile of this document is as valid as the original.

____ __ __/__ __/20 __ __
Signature of WHI Participant (or Authorized Representative) Today's Date

____ __ __/__ __/19 __ __
Printed Name of WHI Participant (or Legally Authorized Representative and relationship to participant) Date of Birth

Form 33

Spanish translation under way.

Instructions to WHI staff under way.